WHY THE ROBERTS COURT'S HEALTH CARE RULING DOOMS THE AFFORDABLE CARE ACT TO FAILURE

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Pundits, policy wonks, and law professors (including this author) were surprised by the Supreme Court's June 28, 2012 ruling on the constitutionality of the Patient Protection and Affordable Care Act (ACA).[1] Most observers expected either a 5-to-4 vote striking the ACA's so-called "individual mandate" as an overbroad attempt to regulate interstate commerce or a 5-to-4 or 6-to-3 vote upholding the mandate as a valid exercise of Commerce Clause power. Instead, five justices, including Chief Justice Roberts, agreed that a mandate to purchase health insurance from a private company would exceed Congress's authority under the Commerce Clause,[2] but a different five-justice majority, again including the Chief Justice, read the statute not to impose a strict mandate to purchase health insurance but instead to levy a constitutionally valid tax for failure to do so.[3]

The Court also surprised observers by ruling 7-to-2 that the ACA unconstitutionally coerces the states by threatening to deny all federal Medicaid funding—not just expansion funding—to states that do not expand their Medicaid rolls as the statute prescribes.[4] While prior Supreme Court precedents had recognized the theoretical possibility that Spending Clause legislation could unconstitutionally commandeer recipient states,[5] no spending legislation had actually been struck on coercion grounds. Few observers expected the state challengers to succeed on their coercion argument, particularly by a 7-2 vote.

Now that the dust has settled somewhat, we may assess the likely consequences of *National Federation of Independent Business v. Sebelius* (hereinafter, *NFIB*). This Commentary briefly summarizes the reasoning underlying the decision's individual mandate ruling. It then considers what lies ahead for health insurance and medical care in the United States if the ACA, as modified by *NFIB*, is not repealed. Be warned: the picture isn't pretty.

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1 National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012).

2 *Id*. at 2585-91 (Roberts, C.J.); *id*. at 2645-50 (joint dissent of Justices Scalia, Kennedy, Thomas, and Alito).

3 *Id*. at 2594-2600 (Roberts, C.J., joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan).

4 *Id*. at 2601-08 (Roberts, C.J., joined by Justices Breyer and Kagan); *id*. at 2659-66 (joint dissent of Justices Scalia, Kennedy, Thomas, and Alito).

5 *See*, *e.g.*, South Dakota v. Dole, 483 U.S. 203, 211 (1987) ("Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'") (quoting Steward Machine Co. v. Davis, 301 U.S. 548, 590 (1937)).

The Roberts Court's Decision

As both Justice Roberts' opinion for the Court and the joint dissent of Justices Scalia, Kennedy, Thomas, and Alito emphasized, our federal government is one of limited powers.[6] The Bill of Rights—Amendments I through X, collectively—precludes the government from imposing rules and taking actions that violate certain fundamental rights like the freedoms of speech, association, and religion. In addition, Article I of the Constitution limits congressional power by exhaustively cataloguing the things Congress is authorized to do; congressional action that is not authorized is forbidden. Accordingly, for an act of Congress to pass constitutional muster, it must be both authorized by the empowering provisions of Article I and not forbidden by the constraints in the Bill of Rights.

The primary issue in *NFIB* was whether the so-called individual mandate—the provision of the ACA requiring most individuals to purchase health insurance or pay a penalty to the government[7]—was authorized by Article I. The government contended that the mandate was authorized by Congress's express power to "regulate Commerce…among the several States."[8] The state challengers, by contrast, maintained that individuals who had elected not to purchase health insurance had not thereby engaged in commerce, so forcing them to do something commercial—to *enter* commerce—was not itself a *regulation* of commerce. Five members of the Court (Chief Justice Roberts and Justices Scalia, Kennedy, Thomas, and Alito) agreed and held that the Commerce Clause does not authorize Congress to order individuals to purchase insurance from a private company.[9] They further agreed that the mandate was not authorized by the Article I provision empowering Congress to "make all Laws which shall be necessary and proper" for carrying out its Commerce Clause authority.[10] The mandate was not "proper," the five justices concluded, because it would compel, not regulate, commerce, and any power conferred by the Necessary and Proper Clause must be incidental to, not greater than, the expressly enumerated powers.[11]

But all this was not enough to undermine the individual mandate's constitutionality. Having concluded that the mandate is not a valid exercise of Congress's authority under the Commerce and Necessary and Proper Clauses, Justice Roberts invoked a longstanding interpretive canon that calls for the Court, if possible, to interpret statutes in a way that preserves their constitutionality.[12] Because he had determined that the mandate

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6 *NFIB*, 132 S. Ct. at 2577-79 (Roberts, C.J.); *id*. at 2643 (joint dissent of Justices Scalia, Kennedy, Thomas, and Alito).

7 26 U.S.C.A. § 5000A.

8 U.S. Const. Art. I, § 8, cl. 3.

9 *NFIB*, 132 S. Ct. at 2585-91 (Roberts, C.J.); *id*. at 2645-50 (joint dissent of Justices Scalia, Kennedy, Thomas, and Alito).

10 U.S. Const. Art. I, § 8, cl. 18.

11 *NFIB*, 132 S. Ct. at 2591-93 (Roberts, C.J.); *id*. at 2645-47 (joint dissent of Justices Scalia, Kennedy, Thomas, and Alito).

12 *See*, *e.g.*, Blodgett v. Holden, 275 U.S. 142, 148 (1927) (concurring opinion) ("[T]he rule is settled that as between two possible interpretations of a statute, by one of which it would be

could not be upheld on the aforementioned grounds,[13] Justice Roberts was willing to adopt what he characterized as a "fairly possible,"[14] though concededly not the "most straightforward,"[15] reading of the ACA—namely, that the statute does not make it *illegal* not to buy health insurance but instead merely imposes a tax, labeled a "penalty," on the failure to do so. Congress's calling the payment a penalty rather than a tax, Justice Roberts reasoned, was enough to preclude application of the Anti-Injunction Act,[16] which limits courts' jurisdiction to hear challenges to tax laws but, as a mere statute, may be overridden by congressional action.[17] But, according to the Chief Justice and four other justices, congressional labeling alone is not enough to keep a penalty from amounting to a tax for constitutional purposes.[18] The penalty for not buying insurance is constitutionally a tax, the majority reasoned, because it is relatively small in size, has no "scienter" requirement (*i.e.*, does not require an *intentional* failure to purchase insurance), and is collected by the Internal Revenue Service (IRS).[19] Accordingly, the penalty for failure to purchase insurance is constitutionally authorized as long as it meets the Constitution's restrictions on Congress's taxing power.[20] The majority concluded that it does.[21]

Constitutional law scholars will spend years dissecting the reasoning and exploring the broad implications of *NFIB'*s individual mandate ruling, and an exhaustive constitutional analysis of the decision is beyond the purview of this Commentary. Instead, the remainder of the Commentary focuses on the narrower and more immediate issue of how the modified ACA will alter health insurance and medical care in the United States.

Implications for Health Insurance and Medical Care in the U.S.

In June 2009, at the outset of the health care reform debate, President Obama's Council of Economic Advisers identified "two key components of successful health care reform: (1) a genuine containment of the growth rate

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unconstitutional and by the other valid, our plain duty is to adopt that which will save the Act.").

13 *NFIB*, 132 S. Ct. at 2600-01.

14 *Id*. at 2594.

15 *Id*. at 2593.

16 26 U.S.C.A. § 7421(a).

17 *NFIB*, 123 S. Ct. at 2583 ("The Anti-Injunction Act and the Affordable Care Act, however, are creatures of Congress's own creation. How they relate to each other is up to Congress, and the best evidence of Congress's intent is the statutory text.").

18 *Id*. at 2594 ("It is up to Congress whether to apply the Anti-Injunction Act to any particular statute, so it makes sense to be guided by Congress's choice of label on that question. That choice does not, however, control whether an exaction is within Congress's constitutional power to tax.").

19 *Id*. at 2595-96.

20 *See* U.S. Const., Art. I, § 9, cl. 4 ("No Capitation, or other direct, Tax shall be laid, unless in Proportion to the Census of Enumeration herein before directed to be taken.").

21 *Id*. at 2599 (concluding that tax for failure to carry insurance is not a "direct" tax and thus does not run afoul of Art. I, § 9, cl. 4).

of health care costs, and (2) the expansion of insurance coverage."[22] When the ACA was finally enacted, it became apparent proponents had deemphasized the former component and focused almost exclusively on the latter. As interpreted and modified by the *NFIB* Court, however, the ACA is likely to provide neither. Instead, we can expect (1) health insurance premiums to rise; (2) the underlying cost of medical care—the primary driver of insurance premiums—to continue to grow at pre-ACA, or perhaps higher, rates; and (3) insurance coverage to expand less than ACA proponents predicted.

Health Insurance Premiums

As the government repeatedly stressed in the *NFIB* argument, the individual mandate was necessary because of two constraints the ACA places on insurance companies. The first, "guaranteed issue," precludes insurance companies from denying or dropping coverage because of preexisting conditions.[23] The second, "community rating," requires insurers to set premiums solely on the basis of age, smoker status, and geographic area, without charging higher premiums to sick people or those susceptible to sickness.[24] Taken together, these two constraints on insurance pricing create a perverse incentive for young, healthy people to refrain from purchasing health insurance until they need medical care. After all, they can always obtain coverage immediately upon becoming ill or injured (thanks to guaranteed issue), and (thanks to community rating) the insurer is forbidden to charge them a higher price reflective of the virtual certainty that they will make large claims. The penalty-backed individual mandate was designed to prevent young, healthy people from dropping or declining to purchase insurance, thereby leaving only the older and infirm in the covered population.

If young, healthy people do exit the pool of premium-paying insureds insurance premiums will skyrocket. That is because health insurance premiums are based on the likely health care expenditures of the covered population. The greater the percentage of young and healthy (low expenditure) individuals in that group, the lower the resulting premiums. Conversely, when the young and healthy drop out so that the pool of insureds is, on average, older and more infirm, premiums will rise. And, of course, the higher insurance premiums rise, the more sensible it becomes for the relatively healthy to drop their insurance, pay the small "tax" instead, and wait to get sick before signing up for increasingly costly coverage. Efficacious penalties for failure to purchase insurance, then, are required to prevent "adverse selection" and ensure that insurance policies, as regulated by the ACA, remain affordable.

But penalties do not deter if they are set too low. Say, for example, that a parking meter costs a dollar, but the penalty for not feeding the meter is only a quarter. Who would feed the meter? Unless the expected penalty for

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[22] EXECUTIVE OFFICE OF THE PRESIDENT, COUNCIL OF ECONOMIC ADVISERS, THE ECONOMIC CASE FOR HEALTH CARE REFORM ii (June 2, 2009).

[23] 42 U.S.C.A. §§ 300gg-1, 300gg-3, 300gg-4(a).

[24] 42 U.S.C.A. §§ 300gg(a)(1), 300gg-4(b).

an expired meter (the fine times the likelihood of detection) exceeds a dollar, feeding the meter is irrational.[25]

The ACA creates a similar situation because the statutory penalty for not carrying health insurance is quite low, much lower than the cost of insurance. As Justice Roberts observed:

> [I]ndividuals making $35,000 a year are expected to owe the IRS about $60 for any month in which they do not have health insurance. Someone with an annual income of $100,000 a year would likely owe about $200. The price of a qualifying insurance policy is projected to be around $400 per month.[26]

It makes little sense for a young, healthy person in this situation to pay $400/month for health insurance when she can instead opt to pay a penalty of $60/month until she needs health care, at which point she can contact a health insurer and be assured of coverage (because of guaranteed issue) at rates not reflecting her impaired health (because of community rating).[27]

Now, this analysis does not account for subsidies the ACA provides to purchase health insurance. Families earning up to four times the federal poverty level (FPL) may qualify for a subsidy on health insurance purchased on a state exchange that complies with the ACA.[28] But there are two reasons to believe that, even with these subsidies, many young and healthy people will refrain from purchasing health insurance. First, the subsidies are too small. For subsidy-eligible families (those earning up to 400% FPL), the annual penalty for failure to purchase insurance will never exceed $2,085 (adjusted for inflation from 2016 dollars).[29] Out-of-pocket

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[25] *See generally* A. Mitchell Polinsky & Steven Shavell, *Punitive Damages: An Economic Analysis*, 111 HARV. L. REV. 869 (1998).

[26] *NFIB*, 132 S. Ct. at 2596 n. 18 (citing D. Newman, *CRS Report for Congress, Individual Mandate and Related Information Requirements Under PPACA* 7, and n. 25 (2011)).

[27] The fact that the ACA phases in the penalties for failure to purchase health insurance exacerbates the adverse selection problem by creating particularly perverse incentives at the outset. In the first two years the insurance mandate is in place, the penalty for failure to carry insurance is significantly reduced. *See infra* note 29 (explaining the "phased-in" penalty provisions of 26 U.S.C. § 5000A(c)). This slow phase-in will encourage younger, healthier individuals and families to opt to pay the low penalty rather than purchase insurance in those first two years. The exodus of those individuals from the pool of insured will cause premiums to rise abruptly, which will encourage even more of the younger, healthier insureds to exit the pool. Gaining control of the adverse selectionencouraged at the mandate's outset may prove difficult.

[28] *See* 26 U.S.C. § 36B. The available subsidies will be inversely calibrated to income levels, shrinking as family income grows. *See generally* Chris L. Peterson & Thomas Gabe, *CRS Report for Congress, Health Insurance Premium Credits Under PPACA (Pub. L. 111-148)* (2010).

[29] The penalty for failure to have minimum essential health insurance is the greater of:

1. A flat dollar amount per person (for adults, $95 in 2014, $325 in 2015, $695 in 2016 and beyond, adjusted for inflation; for children, half the adult penalty), with the flat amount per family never exceeding three times the adult amount; or
2. A percentage of income (1% in 2014, 2% in 2015, and 2.5% in 2016 and beyond) above the tax-filing threshold (estimated to be around $10,250 for single filers and $20,500 for joint filers in 2016).

See 26 U.S.C.A. § 5000A(c). The maximum penalty under the second measure (percentage of income) would be approximately $1,700 per year. The maximum annual penalty under the first measure would be $2,085 (adjusted for inflation from 2016 dollars).

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costs for subsidized insurance, by contrast, will be significantly more than that amount for all but the poorest families.[30] The following table catalogues for different family income levels the maximum income percentage and out-of-pocket dollars the family will have to pay for subsidized insurance in 2016, the percentage difference in outlays for the family's two options (buy insurance or pay the penalty), and the family's likely decision.[31]

Family Income	Max. % of Income to be Spent on Ins.	Dollars to be Spent on Ins.	Comparison of Out-of-Pocket Insurance Expense vs. Penalty	Likely Decision
$35,000	3.97%	$1,388	Penalty is 50% more than ins	Buy
$40,000	4.96%	$1,982	Penalty is 5.2% more than ins	Buy
$45,000	5.94%	$2,672	Ins costs 1.28 times penalty	Don't buy
$50,000	6.77%	$3,385	Ins costs 1.62 times penalty	Don't buy
$55,000	7.52%	$4,135	Ins costs 1.98 times penalty	Don't buy
$60,000	8.23%	$4,937	Ins costs 2.36 times penalty	Don't buy
$65,000	8.85%	$5,751	Ins costs 2.76 times penalty	Don't buy
$70,000	9.47%	$6,626	Ins costs 3.18 times penalty	Don't buy
$75,000	9.50%	$7,125	Ins costs 3.42 times penalty	Don't buy
$80,000	9.50%	$7,600	Ins costs 3.65 times penalty	Don't buy
$85,000	9.50%	$8,075	Ins costs 3.87 times penalty	Don't buy
$90,000	9.50%	$8,550	Ins costs 4.1 times penalty	Don't buy
$95,000	No max	Policy cost	Ins costs > 4 times penalty	Don't buy
$100,000	No max	Policy cost	Ins costs > 4 times penalty	Don't buy

As the table reveals, at all but the lowest income levels it makes more sense for healthy families to refrain from purchasing insurance and pay the penalty until insurance coverage is needed. In fact, until 2016, even families with the lowest two income levels on the table would be better off foregoing insurance purchases. Because the no-insurance penalties are phased in between 2014 and 2016 (they are only $285 in 2014 and $975 in 2015), they are initially less than the out-of-pocket cost of a qualifying insurance policy.[32] It is likely, then, that even low-income healthy families

[30] *See generally* PAUL R. HOUCHENS, MILLIMAN RESEARCH REPORT: MEASURING THE STRENGTH OF THE INDIVIDUAL MANDATE 3 (Mar. 2012) (available at http://publications.milliman.com/publications/health-published/pdfs/measuring-strength-individual-mandate.pdf).

[31] Maximum income percentages and dollar amounts to be spent on health insurance are from the Kaiser Family Foundation Health Reform Subsidy Calculator, available at http://healthreform.kff.org/SubsidyCalculator.aspx.

[32] *See supra* note 29

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will drop out of the insurance pool in 2014 and 2015, driving up insurance premiums for those remaining in the pool.[33]

In addition to being too small, the subsidies for purchasing insurance may not be available in many states. The text of the ACA provides for the subsidies only on purchases made through exchanges that *the states* voluntarily establish.[34] While proponents of the ACA presumably assumed that all states would establish such exchanges so as to make subsidies available to their citizens, a great many states (36 as of the time this Commentary is being drafted) either have declared an intention not to set up a state exchange or have made little movement in the direction of doing so.[35] The IRS has taken the position that the subsidies should also be available through federal exchanges set up as a "fallback" in states that do not establish their own.[36] It insists that expanding the subsidies is consistent with the purpose of the statute.[37] That is not altogether clear, for legislative history suggests that Congress deliberately provided subsidies only through state-established exchanges in order to encourage states to set up and manage such exchanges.[38] In any event, the statutory language limiting subsidies to state exchanges is quite clear, and courts are generally loathe to exalt a statute's purported purpose over its clear text, particularly when congressional intent is ambiguous.[39]

In the end, then, the ACA sets penalties that are too low to induce young and healthy people to purchase insurance, even when their purchases are subsidized as the statute provides. Proponents of the ACA, who certainly understood the perverse incentives created by mandating guaranteed issue and community rating, must have recognized that the penalties were too

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[33] *See supra* note 27.

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[34] 26 U.S.C.A. § 36B(c)(2)(A) (defining "coverage month" for which premium assistance credit is available as any month on the first day of which the taxpayer was enrolled in a qualified health plan "enrolled in through an Exchange established by the State under section 1311" of the ACA). *See* Jonathan Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits under the PPACA*, forthcoming in HEALTH MATRIX: JOURNAL OF LAW-MEDICINE, draft available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2106789. *But see* Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH (Sept. 11, 2011) (available at http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/) (contending that ACA's limitation of subsidies to purchases on state exchanges reflects drafting error that courts should ignore and arguing that statutory ambiguity warrants deference to IRS rule that subsidies are available on federally established exchanges).

[35] Adler & Cannon, *supra* note 34, at 3 ("As of June 2012, only 14 states and the District of Columbia had taken affirmative steps to create a PPACA-compliant Exchange.").

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[36] Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 FED. REG. 30378 (May 23, 2012).

[37] *Id*. ("[T]he final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.").

[38] Adler & Cannon, *supra* note 34, at 34-36 (SSRN draft) (discussing comment by primary ACA author that a state's establishment of exchange was a condition for state's residents to receive premium assistance tax credits).

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[39] *See* Adler & Cannon, *supra* note 34, at 43-63 (rebutting arguments for disregarding plain language of statute).

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low to prevent widespread adverse selection. They likely assumed, though, that the deficient penalties for failure to carry insurance were a "bug" that Congress would eventually fix once the Act was put in place and became operative. During debate over the ACA, proponents needed for the penalties to be low so that they could maneuver the statute through the political process; they figured they could fix the deficiencies later.

The *NFIB* decision, however, limits Congress's ability to increase the penalty for not carrying health insurance. The small size of the penalty was one of three factors that, according to Chief Justice Roberts, transformed the penalty into a tax for constitutional purposes. He explained:

> [T]he shared responsibility payment may for constitutional purposes be considered a tax, not a penalty: *First, for most Americans the amount due will be far less than the price of insurance, and, by statute, it can never be more. It may often be a reasonable financial decision to make the payment rather than purchase insurance, unlike the "prohibitory" financial punishment in* Drexel Furniture. Second, the individual mandate contains no scienter requirement. Third, the payment is collected solely by the IRS through the normal means of taxation—except that the Service is not allowed to use those means most suggestive of a punitive sanction, such as criminal prosecution.[40]

This reasoning suggests that the penalty for failure to carry health insurance can count as a tax for constitutional purposes only if it is kept so small as to be largely ineffective. *NFIB* thus transformed what was effectively a "bug" in the ACA into a "feature" of the statute—one that is required for the Act to constitute a valid exercise of congressional power. Absent the power to increase penalties substantially, the only means Congress has for inducing young, healthy people to buy insurance is to increase premium subsidies to bring out-of-pocket expenses into line with expected penalties. Given the nation's dire fiscal situation, the political will to take that tack may prove lacking. Somewhat ironically, then, the *NFIB* decision may have damned the ACA to failure in the process of saving it from constitutional challenge.

Underlying Medical Costs

The toxic combination of guaranteed issue, community rating, and constitutionally limited low penalties for failure to purchase health insurance would not doom the ACA if the Act significantly reduced medical costs across the board. While adverse selection would generate a somewhat riskier pool of insureds, the reduced costs per claim might offset the increased number of claims per insured, driving total medical costs (and thus insurance premiums) downward. Unfortunately, the ACA does precious little to reduce the costs of medical care itself, as opposed to health insurance. In fact, it will likely cause underlying medical costs to rise.

The ACA's primary measures aimed at constraining costs of medical care itself are (1) increased funding for ferreting out "waste, fraud, and abuse"; (2) price controls (administered by the Independent Payment Advisory

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[40] *NFIB*, 132 S. Ct. at 2595 (emphasis added, internal citation omitted).

Board) on Medicare charges; (3) comparative effectiveness research aimed at determining which medical procedures are most cost-effective; (4) measures to encourage preventive care; (5) authorization for "Accountable Care Organizations" (ACOs), collaborations among medical care providers who are offered a modest financial incentive to coordinate care so as to reduce redundancy, unnecessary testing, etc.; and (6) an excise tax to discourage extremely generous employer-provided health care plans that lead consumers to ignore medical prices and overconsume health care services.[41]

Unfortunately, none of these measures will likely have much cost-reducing effect. The first may be a cost-effective effort, but officials have been attempting to reduce "waste, fraud, and abuse" for decades, and there is little reason to believe this particular attempt will be anomalously successful. The second affects Medicare expenditures only and will likely lead to either reduced services for Medicare beneficiaries or price discrimination against non-Medicare consumers of the services at issue, who will be charged higher prices to make up for the Medicare cuts. Comparative effectiveness research (#3) is probably a good initiative (information, after all, has characteristics of a public good and is thus frequently underproduced), but such research will reduce costs only if health care providers actually use it in making treatment decisions. Given that doctors tend to think their patients are unique and should not be confined to "off the rack" treatments, and insured patients have little or no incentive to pressure their physicians to follow the most cost-effective treatment regimens, it is difficult to believe that comparative effectiveness research will reduce overall health care costs by a significant percentage. The same goes for the ACA's preventive care efforts (#4), which amount mainly to grants for demonstration projects, etc., or to mandates that insurers provide preventive measures free of charge.[42] (For reasons detailed below, mandating insurance coverage for all preventive measures will likely increase the cost of those measures in the long run.)[43] As for ACOs (#5), any cost-savings from collaboration among competing providers must be reduced by the amount of price-enhancing collusion such organizations facilitate. Given that the payoff for ACO members who successfully collude to raise prices would dwarf any likely "shared savings" from coordination, the competitor coordination the statute's ACO provisions encourage is more likely to increase than to reduce providers'

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[41] *See* Robert Wood Johnson Foundation, Health Policy Connection: Health Care Costs, *How does the Affordable Care Act attempt to control health care costs?* (July 2011) (summarizing features of ACA aimed at reducing underlying medical costs) (available at http://www.rwjf.org/files/research/howdoestheacaattempttocontrolhealthcarecosts.pdf); Christina D. Romer, *Only the First Step in Containing Health Costs*, N.Y. TIMES (New York Ed.) BU6 (July 22, 2012) (same); Anna Wilde Mathews, *Can Accountable-Care Organizations Improve Health Care While Reducing Costs?*, WALL ST. J. (Jan. 23, 2012) (discussing cost-saving rationale for Accountable Care Organizations).

[42] *See* Kaiser Family Foundation, Focus on Health Reform, *Summary of New Health Reform Law* 10-11 (Apr. 15, 2011), available at http://www.kff.org/healthreform/upload/8061.pdf (summarizing "Prevention/Wellness" provisions of ACA).

[43] *See infra* notes 52-53 and accompanying text.

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prices.[44] That leaves the excise tax for particularly generous insurance policies (#6). For reasons explained next, that tax is a good, but far too limited, initiative.

When it comes to the medical costs that underlie insurance premiums, the glaring omission in the ACA is its failure to address what is perhaps the primary driver of health care inflation: the lack of price competition among providers of medical services. In competitive markets, price is driven down to the level of the producer's incremental cost (which usually falls with technological development and increased specialization) as competing producers vie for customers. But producers will lower their prices *only if* doing so brings them more business, and lower prices will enhance sales *only if* customers (at least "marginal" customers—those most price-sensitive) actually shop on price. When a third party pays for the consumer's purchase, the consumer has little incentive to consider price when determining from whom to purchase. Thus, health insurance tends to make consumers price-insensitive, thereby destroying providers' incentive to compete on price.

As health insurance has transitioned from covering only unpredictable and catastrophic expenses (like emergency surgeries and unexpected hospitalizations) to covering even expected, low-cost services (like office visits and vaccinations), and as copayments have been reduced or eliminated, consumers' incentives to take price into consideration when selecting medical service providers have virtually disappeared. It is not at all surprising, then, that a 2005 Harris Interactive Poll of 2,000 insured adults found that the average survey participant could predict the price of a Honda Accord within $300 but was off by a whopping $8,100 when it came to estimating the price of a four-day hospital stay.[45] Why research prices (or turn down low-value services) when someone else is paying? And why would providers lower their prices (or refrain from recommending services of little value) when consumers routinely ignore price in making purchase decisions?

Things change drastically when consumers have to foot the direct bill for medical treatment. Consider, for example, the price of LASIK eye surgery, which insurance generally does not cover. In 1999, prices for the procedure averaged $2,106 per eye. By 2010, the average price in real (1999) dollars had fallen 21% to $1,658 per eye, despite significant improvements in the

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[44] *See generally* Joe Miller, *The Proposed Accountable Care Organization Antitrust Guidance: A First Look*, HEALTH AFFAIRS BLOG (April 4, 2011) (available at http://healthaffairs.org/blog/2011/04/14/the-proposed-accountable-care-organization-antitrust-guidance-a-first-look/) (observing that while ACOs are predicted to generate nationwide savings of $510 million over three years, the annual operating revenues of hospitals in St. Louis, Missouri alone exceed $7 *billion*, so the incentive to utilize ACOs as a front for collusion will be significant); Joe Miller, *Accountable Care Organizations: Will Consumers Be Protected?*, HEALTH AFFAIRS BLOG (Nov. 7, 2011) (available at http://healthaffairs.org/blog/2011/11/07/accountable-care-organization-antitrust-guidance-will-consumers-be-protected/).

[45] GREAT-WEST HEALTH CARE, CONSUMER ATTITUDES TOWARD HEALTH CARE 4 (Aug. 2005) (available at http://www.benefitdesign.com/Great-WestHealthcareConsumerAttitudesSurvey_2005.pdf).

technology.[46] Similarly, prices for cosmetic surgery have consistently fallen over time despite both technology improvements and increased demand. In the three years preceding 2009, purchases of laser skin resurfacing increased by 456% among men and 215% among women, but prices fell even in nominal terms.[47] Before this surge in demand, the average procedure cost $2,317; by 2010, it had declined to $2,232 (nominal dollars).[48] Prices for medical services overall, by contrast, have risen sharply over time. From 1999 to 2010, when LASIK prices fell 21% in real terms, real prices for medical services rose by 22%.[49] What accounts for this difference in price trends? In large part, the vigorous price competition resulting from the fact that consumers of LASIK and cosmetic surgery take price into account because they must pay out-of-pocket.

The lesson for health care reformers is that if we want to stop the upward spiral of health care costs—the real source of America's purported health care crisis—we need to find ways to motivate providers to compete on price. Expanding insurance coverage does not help here; such expansion results in even less price-comparison among consumers and tends to encourage providers to raise prices and to oversell unnecessary or marginally useful medical services.

A better policy would encourage consumers to pay directly (out-of-pocket) for a more significant portion of their health care consumption so that providers have an incentive to compete on value. Increasing deductibles and copayments, while encouraging consumers to prepare for higher out-of-pocket costs by maintaining tax-advantaged Health Savings Accounts, would help on this front. Current policy, though, discourages high-deductible, high-copayment insurance policies. Right now, employer contributions to health insurance, but not individuals' own expenditures on such insurance, are not taxed.[50] This creates an incentive for employers to replace salary, upon which their employees are taxed, with more generous health insurance benefits (*i.e.*, low deductibles, low copayments, lots of costly coverages), which are tax-advantaged. Those generous benefits, in

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[46] Matt Palumbo, *How the Free Market Can Cure Health Care*, AMERICAN THINKER (Dec. 17, 2011) (available at http://www.americanthinker.com/2011/12/how_the_free_market_can_cure_health_care.html), citing Liz Segre, *Cost of LASIK Eye Surgery and Other Corrective Procedures* (Oct. 13, 2011) (available at http://www.allaboutvision.com/visionsurgery/cost.htm). (Note that 2010 average price of LASIK, $2,756 per eye, was converted to 1999 dollars using Consumer Price Index for all items.)

[47] Palumbo, *supra* note 46.

[48] *Id.*

[49] Using a base of 100 tied to 1982-84 dollars, the CPI for medical services increased from 251.3 in 1999 to 404.937 in 2010. For all items, the CPI (using the same base) was 164.3 in 1999 and 216.687 in 2010. (Databases available at http://data.bls.gov/pdq/SurveyOutputServlet). Adjusting the change in medical service prices to account for inflation as a whole (31.88% over the 11-year period, according to the CPI for all items) reveals that prices of medical services from 1999-2010 grew by 22.18% in real terms.

[50] 26 U.S.C.A. § 106(a). *See generally* Bob Lyke, *CRS Report for Congress: The Tax Exclusion for Employer-Provided Health Insurance: Policy Issues Regarding the Repeal Debate* 3-5 (Nov. 21, 2008) (available at http://www.allhealth.org/briefingmaterials/rl34767-1359.pdf).

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turn, discourage both price competition and thoughtful decisions about health care consumption.

Proponents of the ACA understood this reasoning, as evidenced by an ACA architect's recent remark that overly generous insurance plans "lead families to be less vigilant consumers of health care."[51] The Act's excise tax on the most generous employer-provided plans is a step in the right direction. ACA proponents missed a crucial opportunity, though, in failing to correct the inequitable tax treatment that encourages employers to compensate their workers with more generous benefits rather than increased salary. Moreover, the Act exacerbated the problem of anemic price competition by mandating that insurance plans fully cover, with no copayment, all preventive services.[52] If consumers pay nothing for a preventive service regardless of its price, they have little incentive to select relatively cost-effective services, and providers therefore have little incentive to compete on price. Automobile insurers understand this principle. They do not raise premiums slightly and cover routine oil changes—even though regular oil changes prevent higher costs down the road—because they know that insurance coverage would destroy price competition among mechanics and drive up the price of oil changes.[53] By the same token, the ACA's mandate that insurers fully cover all preventive health services is sure to increase the price of those services in the future.

Insurance Coverage

As mentioned above, the ACA's framers chose to pursue increased insurance coverage over reduced medical costs. As implemented in light of *NFIB*, however, it is unlikely that the Act will expand coverage as much as its proponents hoped and promised.

First, a number of states—including some very populous ones—are likely not to expand Medicaid as the statute prescribes. Recall that one of the holdings of *NFIB* was that Congress could not cut off *all* federal Medicaid funding to states that did not expand their Medicaid rolls to cover all individuals and families earning up to 133% of FPL (doing so would impermissibly "commandeer" the states). Instead, Congress could merely withhold federal expansion funding from noncompliant states.[54] The "carrot" of expansion funding is far less significant than the "stick" of cutting off all federal Medicaid funding, and a number of governors—Democrats and Republicans alike—have expressed reservations about expanding their

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[51] *See* Romer, *supra* note 41 (Christina Romer was Chair of the President's Council of Economic Advisers when the ACA was drafted and enacted.)

[52] 42 U.S.C. § 300gg-13.

[53] *See* John H. Cochrane, *The Real Trouble with the Birth Control Mandate*, WALL. ST. J. (Feb. 9, 2012) ("There are good reasons that your car insurance company doesn't add $100 per year to your premium and then cover oil changes…. You'd have to fill out mountains of paperwork, the oil-change…market[] would become much less competitive, and you'd end up spending more.").

[54] *See supra* note 4 and accompanying text.

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Medicaid rolls.[55] Given the generous federal subsidies available to states that expand their rolls (100% of expansion funding initially, falling to 90% by 2020),[56] most state governments will likely comply with the expansion request. After all, the federal taxes paid by a state's residents ultimately help finance the expansion funding, and resident voters are thus likely to demand some share of that funding. On the other hand, officials in many cash-strapped states have worried that Congress will, in the future, reduce the amount of federal subsidies for the expanded rolls, leaving the states on the hook for the expanded entitlement benefits.[57] Those officials may decide not to expand their states' Medicaid rolls, leaving uninsured many citizens who are not eligible for traditional Medicaid. Those earning less than 133% of FPL would also not be eligible for premium subsidies, which are available only for individuals and families earning 133% to 400% of FPL.[58]

Coverage levels may also disappoint because the ACA encourages employers to drop health plans for lower-income employees, many of whom will not be motivated to purchase insurance on their own. As noted, the federal tax code currently exempts employer-provided health insurance benefits from taxation.[59] That exemption amounts to an implicit subsidy percentage equal to the payroll tax rate plus the recipient employee's marginal income tax rate. Because high-income workers are subject to higher marginal tax rates than are lower-income workers, this implicit subsidy is greatest for them. Moreover, workers earning more than 400% of FPL will get no subsidy to buy insurance if their employer stops providing it.[60] Lower-income workers, by contrast, get less of an implicit subsidy for employer-provided health insurance, are eligible for more generous subsidies on state exchanges if their employer does not provide health insurance benefits,[61] and would therefore prefer to work for employers that do not offer such benefits. Employers competing for workers will respond to these preferences.

Consider, for example, a previously uninsured 45 year-old who earns $35,000 and is required by the ACA to purchase a family insurance policy

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[55] Charlyn Stanberry, *Governors Weighing Medicaid Expansion Options*, POLITIC365 (July 26, 2012) (observing that Republican governors of Florida, Iowa, Kansas, Louisiana, Nebraska, South Carolina, Texas, and Wisconsin have publicly stated an intention not to expand their Medicaid programs; that Republican governors of Alabama, Georgia, Indiana, Mississippi, Nevada, and Virginia have indicated that they will most likely choose not to expand their programs; and that Democratic governors in Delaware, Kentucky, Missouri, Montana, New Hampshire, North Carolina, and West Virginia remain undecided about expanding Medicaid).

[56] 42 U.S.C.A. § 1396d(y)(1).

[57] *See* Avik Roy, *Why States Have a Huge Fiscal Incentive to Opt-Out of Obamacare's Medicaid Expansion*, THE APOTHECARY (July 13, 2012) (available at http://www.forbes.com/sites/aroy/2012/07/13/why-states-have-a-huge-fiscal-incentive-to-opt-out-of-obamacares-medicaid-expansion/).

[58] 26 U.S.C.A. § 36B(b).

[59] *See supra* note 50 and accompanying text.

[60] *See* 26 U.S.C.A. § 36B(b) (providing for premium assistance credits to decrease as income rises and phase-out completely when income reaches 400% of FPL).

[61] *See id.*

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that, in a high cost area, will cost around $15,000 in 2016.[62] If the employer provides the policy, the cash component of the employee's compensation will fall to $20,000 (benefits generally being a dollar-for-dollar substitute for wages). The employee, however, will not have to pay the approximately $3,400 in federal income, Social Security, and Medicare taxes that would otherwise be due on the $15,000 received as insurance rather than cash.[63] On the other hand, if the employer does not provide health insurance and the employee purchases it on a state exchange, the employee will be eligible for a federal subsidy worth around $13,600.[64] Given the choice between a $3,400 implicit tax subsidy and a $13,600 subsidy on the exchange, the employee would prefer the latter. If the employer employed more than 50 workers and failed to provide coverage, then the employer would be charged a penalty of $2,000 for each worker that purchased subsidized insurance (after the first 30 workers).[65] It would likely choose to pay that penalty, however. The employer could finance the payment by reducing the employee's salary by $2,000, and the employee would gladly agree to that arrangement. Even after having his salary diminished by $2,000, the employee would be better off gaining access to the larger government subsidy available only to individuals without employer-provided coverage.

But this analysis shows merely that the ACA encourages employers to drop coverage for lower-income workers. Won't those workers then purchase subsidized policies on the state exchanges? Perhaps not. For many of those workers, it will make more sense to pay the penalty and wait until health care is needed before purchasing insurance.[66] A one-income family of four headed by a 40 year-old earning $50,000, for example, would have to pay $3,385 for qualifying insurance[67] or incur a no-insurance penalty of $2,085,[68] and it could always purchase insurance on a state exchange—with a $9,900 subsidy[69]—the moment coverage became necessary. Such a

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[62] This estimate is based on the Kaiser Health Reform Subsidy Calculator, *supra* note 31, which indicates that the expected 2014 price of a silver-level insurance policy covering a family of four headed by a 45 year-old and living in a high-cost area is $17,094. Because the ACA mandates a minimum of bronze coverage (60% actuarial value) rather than silver coverage (70% actuarial value), we can estimate the price of a qualifying plan to be 86% of the silver plan price (70*.86=60.2). The 2014 cost of a qualifying bronze plan, then, would be $14,701, so the 2016 price would likely approach $15,000.

[63] This assumes a 6.2% Social Security tax rate, a 1.45% Medicare tax rate, and a marginal income tax rate of 15%. (For simplicity, I am ignoring the more minor components of the payroll tax.)

[64] According to the Kaiser Health Reform Subsidy Calculator, *supra* note 31, the maximum percentage of income the family would have to pay for the policy would be 3.97%, which totals $1,390. The total subsidy on a $15,000 bronze policy, then, would be $13,610.

[65] 26 U.S.C.A. § 4980H.

[66] *See supra* notes 28-**Error! Bookmark not defined.** and accompanying text.

[67] *See* Kaiser Health Reform Subsidy Calculator, *supra* note 31. The premium subsidies cap this family's out-of-pocket expenses at 6.77% of income, or $3,385.

[68] The penalty would be ($695*2) + .5($695*2) = $2,085. *See supra* note 29 and accompanying text.

[69] According to the Kaiser Health Reform Subsidy Calculator, *supra* note 31, the 2014 price of a silver insurance plan for the family in the example would be $14,556 (assuming a higher cost geographic region). A qualifying bronze plan should cost around 86% of that amount, or

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family's income level is low enough that the family is better off without employer coverage[70] yet high enough that the family's out-of-pocket insurance expenses will exceed the no-insurance penalty. Families in this situation can be expected *both* to lose employer coverage *and* to refrain from purchasing insurance on a state exchange.

Of course, all this assumes that premium subsidies are indeed available. For reasons set forth above, the ACA seems not to authorize such subsidies in states that fail to establish exchanges and instead rely on the federal government to do so.[71] Employers in such states would have less incentive to drop coverage for low-income employees, but lower income citizens who do not have employer-provided health insurance would not be likely to purchase insurance in such states, where the difference between the non-coverage penalty and the out-of-pocket cost of insurance (without subsidies) would be tremendous.

For all these reasons, the ACA, as constrained by *NFIB*, is unlikely to expand health insurance coverage to anywhere near the level its proponents predicted.

Conclusion

While the *NFIB* decision averted a constitutional ruling that would have eviscerated the constraints government faces as a result of the Constitution's enumeration of congressional powers, the decision left the ACA largely intact. The limitations it did impose, though, are likely to impair further the effectiveness of the already misguided statute. As modified and constrained by *NFIB*, the ACA is likely to drive up both the cost of health insurance premiums and the underlying cost of medical care, without increasing insurance coverage by nearly as much as the Act's proponents promised.

Of course, this grim picture of the future assumes that the ACA is not repealed or significantly amended. Given the Act's continued unpopularity, repeal is a genuine possibility. Congress and the President would do well to replace this ill-conceived statute with a law focused primarily on the most fundamental problem plaguing the American medical system: the lack of vigorous price competition among health care providers. Correcting the tax code provisions that encourage overly generous health insurance policies and thereby assure that consumers of health care pay little or nothing out-of-pocket would be an excellent first step toward tackling the biggest problem facing the American health care system.

$12,518. Assuming inflation is around 3%, the 2016 price of a qualifying policy should be approximately $13,300. The family's contribution would be capped at 6.77% of income, or $3,385, resulting in a subsidy of $9,915.

70 The implicit federal tax subsidy if the employer provided the $13,300 insurance policy would be approximately $3,012 (the sum of the joint filers' Social Security, Medicare, and marginal income tax rates, 22.65%, times the price of the policy). By contrast, if the employer did not provide insurance coverage, the family could obtain a $9,900 subsidy on a state exchange. The family would prefer the latter option.

71 *See supra* notes 34-39 and accompanying text.

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